Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN4897HIC	A. BUILDING _____ B. WING _____	07/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DRIVE RENO, NV 89502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments This Statement of Deficiencies was generated as a result of State licensure survey conducted in your facility from July 22, 2009 to July 28, 2009. This State Licensure survey was conducted by authority of NAC 449, Homes for Individual Residential Care, adopted by the State Board of Health on November 29, 1999. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The census at the time of the survey was three. Three resident files were reviewed and three employee files were reviewed. The following deficiencies were found:	H 000		
H 044	Records of Residents-Copy of physical NAC 449.15527 Agreement between operator of home and resident concerning rates; maintenance of records of residents. (NRS 449.249) The operator of a home shall: 2. Maintain a separate, organized file for each resident of the home and retain the file for 5 years after the resident permanently leaves the home. Each file must include: (c) A copy of the results of a general physical examination of the resident conducted by his physician; and	H 044		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN4897HIC	A. BUILDING _____ B. WING _____	07/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DRIVE RENO, NV 89502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 044	Continued From page 1 This Regulation is not met as evidenced by: Based on record review on July 22, 2009, the facility did not obtain a copy of a general physical examination conducted by a physician on 1 of 3 residents (Resident 3).	H 044		
H 050	Tuberculosis-Employees NAC 441A.375 Medical facilities, facilities for the dependent and homes for individual residential care: Management of cases and suspected cases; surveillance and testing of employees; counseling and preventive treatment. 1. A case having tuberculosis or suspected case considered to have tuberculosis in a medical facility or a facility for the dependent must be managed in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 2. A medical facility, a facility for the dependent or a home for individual residential care shall maintain surveillance of employees of the facility or home for tuberculosis and tuberculosis infection. The surveillance of employees must be conducted in accordance with the recommendations of the Centers for Disease Control and Prevention for preventing the transmission of tuberculosis in facilities providing health care set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. Before initial employment, a person employed in a medical facility, a facility for the dependent or a home for individual residential care shall have a: (a) Physical examination or certification from a	H 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN4897HIC	A. BUILDING _____ B. WING _____	07/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DRIVE RENO, NV 89502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 050	Continued From page 2 licensed physician that the person is in a state of good health, is free from active tuberculosis and any other communicable disease in a contagious stage; and (b) Tuberculosis screening test within the preceding 12 months, including persons with a history of bacillus Calmette-Guerin (BCG) vaccination. If the employee has only completed the first step of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test or other single-step tuberculosis screening test must be administered. A single annual tuberculosis screening test must be administered thereafter, unless the medical director of the facility or his designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 4. An employee with a documented history of a positive tuberculosis screening test is exempt from screening with skin tests or chest radiographs unless he develops symptoms suggestive of tuberculosis. 5. A person who demonstrates a positive tuberculosis screening test administered pursuant to subsection 3 shall submit to a chest radiograph and medical evaluation for active tuberculosis. 6. Counseling and preventive treatment must be offered to a person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200.	H 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN4897HIC	A. BUILDING _____ B. WING _____	07/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DRIVE RENO, NV 89502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 050	Continued From page 3 7. A medical facility shall maintain surveillance of employees for the development of pulmonary symptoms. A person with a history of tuberculosis or a positive tuberculosis screening test shall report promptly to the infection control specialist, if any, or to the director or other person in charge of the medical facility if the medical facility has not designated an infection control specialist, when any pulmonary symptoms develop. If symptoms of tuberculosis are present, the employee shall be evaluated for tuberculosis. (Added to NAC by Bd. of Health, eff. 1-24-92; A 3-28-96; R084-06, 7-14-2006) This Regulation is not met as evidenced by: Based on record review on July 22, 2009, the facility failed to ensure that 3 of 3 caregivers complied with NAC 441A.375 regarding tuberculosis (TB) testing (Employee #1, #2 and #3 all require two-step TB skin tests and physicals).	H 050		
H 055	Tuberculosis-Residents NAC 441A.380 Admission of persons to certain medical facilities, facilities for the dependent or homes for individual residential care: Testing; respiratory isolation; medical treatment; counseling and preventive treatment; documentation. (NRS 441A.120) 1. Except as otherwise provided in this section, before admitting a person to a medical facility for extended care, skilled nursing or intermediate care, the staff of the facility shall ensure that a chest radiograph of the person has been taken within 30 days preceding admission to the facility.	H 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN4897HIC	A. BUILDING _____ B. WING _____	07/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DRIVE RENO, NV 89502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 055	Continued From page 4 2. Except as otherwise provided in this section, the staff of a facility for the dependent, a home for individual residential care or a medical facility for extended care, skilled nursing or intermediate care shall: (a) Before admitting a person to the facility or home, determine if the person: (1) Has had a cough for more than 3 weeks; (2) Has a cough which is productive; (3) Has blood in his sputum; (4) Has a fever which is not associated with a cold, flu or other apparent illness; (5) Is experiencing night sweats; (6) Is experiencing unexplained weight loss; or (7) Has been in close contact with a person who has active tuberculosis. (b) Within 24 hours after a person, including a person with a history of bacillus Calmette-Guerin (BCG) vaccination, is admitted to the facility or home, ensure that the person has a tuberculosis screening test, unless there is not a person qualified to administer the test in the facility or home when the patient is admitted. If there is not a person qualified to administer the test in the facility or home when the person is admitted, the staff of the facility or home shall ensure that the test is performed within 24 hours after a qualified person arrives at the facility or home or within 5 days after the patient is admitted, whichever is sooner. (c) If the person has only completed the first step of a two-step Mantoux tuberculin skin test within the 12 months preceding admission, ensure that the person has a second two-step Mantoux tuberculin skin test or other single-step tuberculosis screening test. After a person has had an initial tuberculosis screening test, the facility or home shall ensure that the person has a single tuberculosis screening test annually thereafter, unless the medical director or his	H 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN4897HIC	A. BUILDING _____ B. WING _____	07/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DRIVE RENO, NV 89502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 055	Continued From page 5 designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. A person with a documented history of a positive tuberculosis screening test is exempt from skin testing and routine annual chest radiographs, but the staff of the facility or home shall ensure that the person is evaluated at least annually for the presence or absence of symptoms of tuberculosis. 4. If the staff of the facility or home determines that a person has had a cough for more than 3 weeks and that he has one or more of the other symptoms described in paragraph (a) of subsection 2, the person may be admitted to the facility or home if the staff keeps the person in respiratory isolation in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200 until a health care provider determines whether the person has active tuberculosis. If the staff is not able to keep the person in respiratory isolation, the staff shall not admit the person until a health care provider determines that the person does not have active tuberculosis. 5. If a test or evaluation indicates that a person has suspected or active tuberculosis, the staff of the facility or home shall not admit the person to the facility or home or, if he has already been admitted, shall not allow the person to remain in the facility or home, unless the facility or home keeps the person in respiratory isolation. The person must be kept in respiratory isolation until a health care provider determines that the person	H 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN4897HIC	A. BUILDING _____ B. WING _____	07/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DRIVE RENO, NV 89502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 055	Continued From page 6 does not have active tuberculosis or certifies that, although the person has active tuberculosis, he is no longer infectious. A health care provider shall not certify that a person with active tuberculosis is not infectious unless the health care provider has obtained not less than three consecutive negative sputum AFIB smears which were collected on separate days. 6. If a test indicates that a person who has been or will be admitted to a facility or home has active tuberculosis, the staff of the facility or home shall ensure that the person is treated for the disease in accordance with the recommendations of the Centers for Disease Control and Prevention for the counseling of, and effective treatment for, a person having active tuberculosis. The recommendations are set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200. 7. The staff of the facility or home shall ensure that counseling and preventive treatment are offered to each person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 8. The staff of the facility or home shall ensure that any action carried out pursuant to this section and the results thereof are documented in the person ' s medical record. (Added to NAC by Bd. of Health, eff. 1-24-92; A 3-28-96; R084-06, 7-14-2006) This Regulation is not met as evidenced by:	H 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN4897HIC	A. BUILDING _____ B. WING _____	07/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DRIVE RENO, NV 89502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 055	Continued From page 7 Based on record review on July 22, 2009, the facility failed to ensure that 3 of 3 residents complied with NAC 441A.380 regarding tuberculosis (TB) testing (Resident #1, #2 and #3 all require two-step TB skin tests).	H 055		
H 999	Final Comments This Regulation is not met as evidenced by: NRS 449.0105 " Home for individual residential care " defined. " Home for individual residential care " means a home in which a natural person furnishes food, shelter, assistance and limited supervision, for compensation, to not more than two persons with mental retardation or with disabilities or who are aged or infirm, unless the persons receiving those services are related within the third degree of consanguinity or affinity to the person providing those services. Based on record reviews, interviews, and observation on 7/22/09, 7/27/09 and 7/28/09, it was determined the facility had admitted three residents, which exceeded their licensing requirement. Findings include: An initial on-site visit was conducted on 7/22/09. Caregiver #2 reported there were currently three residents at the facility. Resident #1: The resident was admitted to the facility on 4/4/09. The resident was observed sitting in a wheelchair due to a cyst on the spine. The resident was diagnosed with congestive heart failure in February 2009 which requires her to use oxygen. A Needs Assessment conducted by the director indicated the resident was	H 999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN4897HIC	A. BUILDING _____ B. WING _____	07/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DRIVE RENO, NV 89502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 999	Continued From page 8 completely dependent in the following areas: bathing, dressing, oral care, transfer, ambulation, and toileting. The Needs Assessment also indicated the resident needed protective supervision. The record review further indicated a monthly rate for occupancy was $3,500.00/month. An interview with Resident #1 was conducted in her private bedroom. The resident confirmed that the caregivers assisted her in the bathroom and with dressing. The resident was alert and oriented to person place and time. Resident #2: The resident was admitted to the facility on 2/26/09 with diagnoses of a possible stroke, mental status change, alzheimer's disease, hypertension, anemia, EKG change, azotemia, and a fall. An Ultimate User Agreement authorizing the facility to possess and administer the resident's medications was signed by the resident and the facility director, Caregiver #1, on 2/26/09. A Needs Assessment conducted on admission by the director indicated the resident required assistance in the following areas: bathing, dressing, oral care, and medications. The Needs Assessment also indicated the resident needed protective supervision. The record review further indicated a monthly rate for occupancy of $1,800.00/month. An interview with Resident #2 was attempted, but the resident only spoke Spanish. Resident #3: The resident was admitted to the facility on 10/30/07. A Needs Assessment was conducted on 10/31/07 by the director that indicated the resident was completely dependent in the following areas: bathing, dressing, oral care, shaving, transfer, ambulation, toileting, and	H 999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN4897HIC	A. BUILDING _____ B. WING _____	07/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DRIVE RENO, NV 89502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 999	Continued From page 9 medications. The Needs Assessment also indicated the resident needed protective supervision. An Ultimate User Agreement authorizing the facility to possess and administer the resident's medications was signed by the resident and the facility director, Caregiver #1, on 8/7/08. The record review further indicated a monthly rate for occupancy of $1,500/month. An interview with Resident #3 was attempted, but due to the resident's hearing problems, the interview was terminated. In an interview with Caregiver #3, she stated that "all three ladies needed help with dressing and in the bathroom." The caregiver also indicated that she administered medication to all three residents. After review of residents records, observations, and interviews with Resident #1, #2 #3 and the caregivers, it was determined that Residents #1, #2 and #3 all required some level of care, supervision and assistance with medications, visiting the bathroom or with bathing. It was determined that the director of the facility had admitted three residents to a facility licensed for two, was over census since 4/4/09 and therefore was operating a Residential Facility for Groups without a license.	H 999		